# MEDICAL DISPUTE RESOLUTION FINDINGS AND DECISION

**PART I: GENERAL INFORMATION**

**Type of Requestor:** (X ) HCP ( ) IE ( ) IC

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|---|---|
| Requestor's Name and Address<br>SURGICAL AND DIAGNOSTIC CENTER<br>729 Bedford-Euless Rd. West, Suite 100<br>Hurst, TX 76053 | MDR Tracking No.: M4-04-4711-01<br>TWCC No.:<br>Injured Employee's Name: |
| Respondent's Name and Address<br>**AMERICAN HOME ASSURANCE CO Box 19**<br>c/o Flahive, Ogden & Latson | Date of Injury:<br>Employer's Name: AMR Corporation<br>Insurance Carrier's No.: YBUC 49768 |

**PART II: SUMMARY OF DISPUTE AND FINDINGS (Details on Page 2, if needed)**

| Dates of Service | | CPT Code(s) or Description | Amount in Dispute | Amount Due |
|---|---|---|---|---|
| From | To | | | |
| 03/27/03 | 03/27/03 | 25295 Tenolysis, flexor or extensor tendon, forearm and/or wrist, single, each tendon | $1594.94 | $0.00 |
| 03/27/03 | 03/27/03 | 85025 | $37.00 | $0.00 |
| 03/27/03 | 03/27/03 | 80059 | $150.00 | $0.00 |
| 03/27/03 | 03/27/03 | 86311 | $50.00 | $0.00 |
| 03/27/03 | 03/27/03 | 80058 | $34.00 | $0.00 |

**PART III: REQUESTOR'S POSITION SUMMARY**

Requestor's Rationale for increased reimbursement or refund as indicated on the TWCC-60 stated, "Our charges are fair and reasonable based on other insurance companies determination of fair and reasonable payments of 85% - 100% of our billed charges. Workers' Compensation carriers are subject to a duty of good faith and fair dealings in the process of workers' compensation claims."

**PART IV: RESPONDENT'S POSITION SUMMARY**

Respondent's Rationale for maintaining the reduction or denial as indicated on the TWCC-60 stated, "Carrier paid fair and reasonable per State Fee Guidelines." Also the Summary of Carrier's Position stated in part, "…There is simply no rationale to justify $2983.94 charged in facility fees. The Carrier has paid Fair and Reasonable, which is the same as those, used by the Texas Workers' Compensation Commission under Rule 134.401 in which the claimant would be receiving 24 hour care as a surgical inpatient for one day.

It is the Respondent's position that the Requestor was paid more than a fair and reasonable amount as determined in accordance with the criteria for payment under the Act. Specifically, the amount paid by the Respondent was more than that which would be allowed under Medicare. Respondent has paid Requestor $1118.00 which is the same amount that a full service hospital would be paid for its facility charges associated with a spinal surgery and a one-day inpatient hospitalization. Such billing is utterly excessive and violates the cost containment policies of the Act and the Commission…"

**PART V: MEDICAL DISPUTE RESOLUTION REVIEW SUMMARY, METHODOLOGY, AND/OR EXPLANATION**

This dispute relates to services provided in an Ambulatory Surgical Center that are not covered under a fee guideline for this date of service. Accordingly, the reimbursement determined through this dispute resolution process must reflect a fair and reasonable rate as directed by Commission Rule 134.1. This case involves a factual dispute about what is fair and reasonable reimbursement for the services provided.

During the rule development process for facility guidelines, the Commission had contracted with Ingenix, a professional firm specializing in actuarial and health care information services, in order to secure data and information on reimbursement ranges for these types of services. The results of this analysis resulted in a recommended range for reimbursement for

workers' compensation services provided in these facilities. In addition, we received information from both ASCs and insurance carriers in the recent rule revision process. While not controlling, we considered this information in order to find data related to commercial market payments for these services. This information provides a very good benchmark for determining the "fair and reasonable" reimbursement amount for the services in dispute.

To determine the amount due for this particular dispute, staff compared the procedures in this case to the amounts that would be within the reimbursement range recommended by the Ingenix study (from 192.6% to 256.3% of Medicare for this particular year – 2003). Additionally, Medicare considers codes 85025, 80059, 86311 and 80058 global to procedure 25295 and $0.00 reimbursement is indicated for the facility. Staff considered the other information submitted by the parties and the issues related to the specific procedures performed in this dispute. After reviewing these facts and the reimbursement previously made on this claim, it was determined that no additional reimbursement was required. The recommendation was then presented to a staff team with health care provider billing and insurance adjusting experience. This team considered the recommendation, discussed the facts of the individual case, and selected the appropriate amount to be order in the final decision.

Based on the facts of this situation, the parties' positions, and the consensus of other experienced staff members in Medical Review, we find that the requestor is **not entitled to** additional reimbursement for these services.

**PART VII: COMMISSION DECISION AND ORDER**

Based upon the review of the disputed healthcare services, the Medical Review Division has determined that the requestor is **not** entitled to additional reimbursement.

**Ordered by:**

| Authorized Signature | Typed Name | Date of Order |
|---|---|---|
| | | 08/11/05 |

**PART VIII: YOUR RIGHT TO REQUEST A HEARING**

If you are unhappy with all or part of this decision, you have the right to appeal the decision. Those who wish to appeal decisions that were issued during the month of August 2005 should be aware of changes to the appeals process, which take effect September 1, 2005.

House Bill 7, recently enacted by the 79th Texas Legislature, provides that an appeal of a medical dispute resolution order that is not pending for a hearing at the State Office of Administrative Hearings (SOAH) on or before August 31, 2005 is not entitled to a SOAH hearing. This means that the usual 20-day window to appeal to SOAH, found in Commission Rule 148.3, will be shortened for some parties during this transition phase. If you wish to seek an appeal of this medical dispute resolution order to SOAH, you are encouraged to have your request for a hearing to the Commission as early as possible to allow sufficient time for the Commission to submit your request to SOAH for docketing. A request for a SOAH hearing should be sent to: Chief Clerk of Proceedings/Appeals Clerk, P.O. Box 17787, Austin, Texas 78744 or faxed to 512-804-4011. A copy of this Decision should be attached to the request.

Beginning September 1, 2005, appeals of medical dispute resolution orders are procedurally made directly to a district court in Travis County [see Texas Labor Code, Sec. 413.031(k), as amended and effective Sept. 1, 2005). An appeal to District Court must be filed not later than 30 days after the date on which the decision that is the subject of the appeal is final and appealable.

**Si prefiere hablar con una persona in español acerca de ésta correspondencia, favor de llamar a 512-804-4812**

**PART IX: INSURANCE CARRIER DELIVERY CERTIFICATION**

I hereby verify that I received a copy of this Decision and Order in the Austin Representative's box.

Signature of Insurance Carrier: _____ Date: _____